U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of EDGAR MICHAUD and DEPARTMENT OF THE NAVY, NAVAL SHIPYARD, Portsmouth, NH

Docket No. 98-444; Submitted on the Record;
Issued October 15, 1999

DECISION and ORDER

Before GEORGE E. RIVERS, DAVID S. GERSON,
A. PETER KANJORSKI

The issue is whether appellant has more than a two percent impairment of his right lower extremity for which he received a schedule award.

On January 25, 1993 appellant, then a 52-year-old carpenter, filed a notice of traumatic injury and claim for compensation alleging that on January 22, 1993 he stepped off a forklift and was pivoting on his right foot to make a turn when he felt a pop in his right knee followed by pain. The Office of Workers' Compensation Programs accepted the claim for acute right knee strain, internal derangement and tear of the posterior horn, and body of the medial meniscus. Appellant did not miss any work but he was assigned to light duty.

On March 15, 1994 appellant filed a traumatic injury claim alleging that on March 10, 1994 his knee became sore after squatting for an extended period of time to drill a lower door jamb. The Office accepted the claim for medial meniscus tear of the right knee and approved arthroscopic surgery, which was performed on April 1, 1994. The Office doubled the claims for knee injury under the March 25, 1994 claim. Appellant received continuation of pay and compensation for wage loss until he was approved for light duty on May 9, 1994. He subsequently retired on May 26, 1994 and filed a Form CA-7 requesting a schedule award.

In a February 1, 1993 report, Dr. David F. Paul, a Board-certified orthopedist and appellant's treating physician, noted that appellant twisted his right knee getting off a forklift, that he had a prior history of swelling in the anterior aspect of the right knee as a teenager and some minor discomfort as an adult. Dr. Paul further noted that appellant underwent arthroscopic surgery in the left knee in 1987, and that x-rays showed old Osgood-Schlatter's disease and degenerative arthritis with small spurs. According to him, appellant suffered from internal derangement of the right knee, likely medial tear due to the work-related injury. Dr. Paul recommended an exercise program and light duty with no climbing or squatting.

In a March 14, 1994 report, Dr. Paul noted that appellant had reinjured his right knee as a result of squatting and fixing a door jamb at work. He reported appellant's prior medical history and recommended arthroscopic surgery for a medial meniscus tear of the right knee. Dr. Paul also diagnosed degenerative arthritis. According to his physical findings, there was no effusion but a markedly tender medial joint line with range of motion about 0 to 90 degrees.

Dr. Paul performed arthroscopic surgery on April 1, 1994. In an April 26, 1994 treatment note, he noted that appellant was recovering satisfactorily from arthroscopic surgery and was able to bend his knee to110 degrees.

In a treatment note dated May 5, 1994, Dr. Paul indicated that appellant experienced increased swelling in his right knee as a result of physical therapy exercises and could only flex his knee to 90 degrees.

In a June 14, 1994 treatment note, Dr. Paul noted that appellant's right knee symptoms seemed to have gone backwards as he was having more discomfort and swelling. He also noted that appellant's knee was aspirated for fluid. Dr. Paul reported physical findings of 3-plus effusion and about 135 degrees flexion.

In an October 24, 1994 treatment note, Dr. Paul noted that appellant had a range of motion of 0 to 120 degrees with no definite effusion and only mild tenderness. He also reported that appellant was walking well in the office with only a slight limp.

In an April 24, 1995 treatment note, Dr. Paul reported that appellant was retired but remained active, walking 3 to 4 miles per day, and that his right knee had improved. He noted physical findings for range of motion of 0 to 125 degrees with no effusion.

In a treatment note dated June 15, 1995, Dr. Paul advised that appellant had been quite active at home doing painting and yard work, but that he was experiencing stiffness in his right knee after prolonged sitting. He noted physical findings which included 2-plus effusion, marked crepitance and range of motion at 0 to 125 degrees.

By letter dated January 31, 1996, the Office requested that Dr. Paul evaluate appellant for a permanent impairment rating in accordance with the fourth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment.*

In a February 12, 1996 report, Dr. Paul noted on physical examination that appellant's range of motion of the right knee averaged 0 to 107 degrees actively, that he had 2-plus crepitance and a mild to moderate limp with a careful gait when he rose from a seated position. He reported that weight-bearing standing AP x-rays of the knees showed a medial joint space of approximately three millimeters (mm) on the right knee versus four mm, with lateral joint spaces on both knees being substantially wider than the medial spaces. Dr. Paul diagnosed that appellant had residual symptoms related to the meniscectomy and moderate degenerative arthritis. He opined that under the A.M.A., *Guides*, appellant's range of motion entitled him to a [four] percent rating of the whole person. He also stated that "removal of the meniscus partially is [one] [percent] of the whole person ...; a limp with mild DJD of the knee is rated at [seven] [percent] of the whole person; arthritis as evidenced by narrowing of the joint line on the

standing x-ray is rated as [seven] [percent] of the whole person." According to Dr. Paul, the existence of moderate degenerative arthritis was confirmed at the time of appellant's arthroscopic surgery and by x-rays taken in 1993, which showed small spurs diffusely. He further stated "[m]eniscus tears and postmeniscectomy absence of substantial portions of the meniscus contributed to arthritis." Dr. Paul concluded his report by finding that appellant had a three percent whole person permanent impairment and a seven and a half percent permanent impairment of the right lower extremity.

In an April 22, 1996 report, Dr. David I. Krohn, an Office medical adviser, noted that while Dr. Paul did not explicitly reference the A.M.A., *Guides*, a finding of mild degenerative joint disease at page3/74, Table 36 appeared to correlate with Dr. Paul's rating of 7 1/2 percent whole person impairment. Dr. Krohn advised that Dr. Paul apparently erred in combining the seven percent impairment with other parts of section 3.2 against the direction of the A.M.A., *Guides*. He further criticized Dr. Paul's report, noting that Dr. Paul "should [have used] the more specific methods" of calculating impairment as directed by the A.M.A., *Guides* at page 3/75, column 2, paragraph 2. With respect to Dr. Paul's finding of seven percent impairment due to degenerative knee arthritis, the Office medical adviser pointed out that since appellant had diffuse spurs in both knees, and evidence for degenerative arthritis less than two months after the first work injury, it was more reasonable to conclude that the presence of degenerative arthritis in the right knee was "more likely due to a chronic, wear and tear condition demonstrable in both knees, predating the injures in question." Dr. Krohn further criticized Dr. Paul's impairment rating based on range of motion, stating that "in each of five of the previous examinations ... right knee flexion was equal to or greater than 110 percent." The Office medical adviser concluded his report by finding that appellant had a two percent impairment correlated to a diagnosis of partial medial meniscectomy at [p]age 3/85, Table 64 of the A.M.A., *Guides*.

In a decision dated May 7, 1996, the Office awarded appellant a schedule award for a two percent permanent impairment of the right lower extremity for the period February 12 to March 23, 1996.

Appellant next submitted a June 26, 1997 report from Dr. Paul which stated that appellant had asked him to provide the tables and page numbers of the A.M.A., *Guides* which he used to calculate appellant's impairment. Attached to the June 26, 1997 report, Dr. Paul attached a copy of his February 12, 1996 report with handwritten notations in the margins which referenced the A.M.A., *Guides*. Specifically, he noted the following: (1) by using the range of motion criteria of Table 41, page 3/78, the rate of impairment was four percent of the whole person; (2) the rating for removal of the meniscus partially at one percent of the whole was found at Table 64, 3/85; (3) seven percent impairment for a limp with moderate DJD of the knee was calculated according to Table 36, page 3/76; and (4) a three percent whole person impairment rating for arthritis was calculated according to Table 62, page 3/83.

In an August 22, 1997 report, Dr. Neven A. Popovic, an Office medical adviser, reviewed the medical record and noted his agreement with Dr. Krohn that Dr. Paul's rating of impairment based on range of motion was unreliable as he reported inconsistent knee range of motion measurements over the years. Dr. Popovic further agreed with Dr. Krohn that a diagnosis-based

estimate of impairment was the most appropriate in this case, and therefore opined that appellant had only two percent impairment using page 85, Table 64 of the A.M.A., *Guides*.

In a decision dated September 5, 1997, an Office hearing representative determined that appellant provided insufficient medical evidence to establish that he was entitled to greater than a two percent impairment schedule award and therefore affirmed the Office's May 7, 1996 decision.

The Board finds that appellant has no more than a two percent impairment of his right lower extremity for which he received a schedule award.

Under section 8107 of the Federal Employees' Compensation Act[1] and section 10.304 of the implementing federal regulations,[2] schedule awards are paid for the loss or permanent disability of certain specified body members, functions or organs. Neither the Act nor the regulations specify the manner in which the percentage of impairment for a schedule award shall be determined. For consistent results and to ensure equal justice for all claimants, the Board has authorized the use of a single set of tables so that there may be uniform standards applicable to all claimants. The A.M.A., *Guides* has been adopted by the Office as a standard for evaluating schedule losses and the Board has concurred in such adoption.[3]

In order to meet his burden, appellant must submit sufficient medical evidence to show a permanent impairment causally related to his employment that is ratable under the A.M.A., *Guides*. The Office's procedures discuss the type of evidence required to support a schedule award. The evidence must show that the impairment has reached a permanent and fixed state and indicate the date this occurred, describe the impairment in detail, and contain an evaluation of the impairment under the A.M.A., *Guides*.

In the instant case, the Office requested that Dr. Paul, appellant's treating physician, determine appellant's impairment rating under the A.M.A., *Guides*. In a February 12, 1996 report, Dr. Paul originally calculated appellant's impairment rating as 7 1/2 percent of the right lower extremity, but he failed to make specific references to the A.M.A., *Guides*. In accordance with Office procedure, the case record was reviewed by an Office medical adviser, Dr. Krohn, who opined that appellant had a two percent lower extremity impairment based on a diagnosis of partial medial menisectomy at page 3/85, Table 64 of the A.M.A., *Guides*. The Office medical adviser's April 22, 1994 report served as the basis for the Office's May 7, 1996 decision granting appellant a two percent schedule award.

Appellant subsequently submitted a copy of Dr. Paul's February 12, 1996 report which was revised by the physician with handwritten notations in the margins referencing certain pages and tables in the A.M.A., *Guides* he utilized to calculate appellant's impairment rating. Upon receipt of Dr. Paul's corrected February 12, 1996 report, the Office had the case file reviewed by

[1] 5 U.S.C. § 8107.

[2] 20 C.F.R. § 10.304.

[3] *Leisa D. Vassar*, 40 ECAB 1287 (1989); *Francis John Kilcoyne*, 38 ECAB 168 (1986).

a second Office medical adviser who agreed with Dr. Krohn that appellant had no more than two percent impairment of the right lower extremity.

The Board finds that the weight of the medical evidence resides with the opinion of Dr. Krohn, the Office medical adviser as opposed to the opinion of Dr. Paul, appellant's treating physician. In his February 12, 1996 report, Dr. Paul never adequately explained how he calculated his rating of seven and one-half percent impairment for the right lower extremity.[4] At one point, Dr. Paul opined that appellant had a four percent impairment for loss of range of motion according to page 3/78, Table 41 of the A.M.A., *Guides*. This finding was based on the physician's determination that appellant averaged 0 to 107 degrees of flexion.[5] As noted by the Office medical adviser, however, during five out of the six examinations held on April 26 and June 14, 1994, April 24, June 15 and October 24, 1995, appellant averaged greater than 110 degrees flexion, which would not warrant a permanent impairment rating.[6] Additionally, on page 3/77 of the A.M.A., *Guides,* it specifically states that if multiple evaluations exist, "inconsistency of a grade between the findings of two observers, or on separate occasions by the same observer, makes the results invalid." Because there is an inconsistency in the medical record between the measurements for flexion obtained by Dr. Paul on separate occasions, his opinion cannot conclusively establish that appellant is entitled to four percent impairment for loss of range of motion.

Dr. Paul also calculated a seven percent lower extremity impairment rating based on x-ray findings of arthritis pursuant to page 3/83, Table 62 of the A.M.A., *Guides.* The Board notes, however, that the Office only accepted this claim for a meniscus tear and not arthritis. Although Dr. Paul made a generalized statement that meniscus tears contribute to the development of arthritis, he did not explain in any detail how appellant's work injury contributed to his arthritis. This is necessary as Dr. Paul noted on several occasions that appellant had arthritis as early as 1993, and within weeks of the first work-related knee injury. Because Dr. Paul failed to provide a rationalized opinion, discussing the role of each of appellant's preexisting knee conditions and his accepted work injury to his permanent impairment, Dr. Paul's opinion is insufficient to establish that appellant is entitled to more than a two percent impairment rating as determined by the Office medical adviser.

Furthermore, the Board rejects Dr. Paul's opinion as he improperly calculated an impairment rating based on a finding that appellant had a limp with moderate degenerative joint disease under the A.M.A., *Guides,* page 3/76, Table 36. The impairment percentages given in Table 36 are only for "full-time derangements of persons who are dependent on assistive

[4] Dr. Paul failed to state whether he relied on one method or combined methods to reach the rating of seven and a half percent and his calculation is not evident from his February 12, 1996 report.

[5] Table 41 indicates that there is 4 percent impairment for flexion less than 110 degrees; *see* A.M.A., *Guides,* page 3/78.

[6] In a treatment note dated September 18, 1996, which was subsequent to his calculation of appellant's impairment rating, the doctor also noted that appellant had full range of motion and was flexing about 120 degrees in his right knee.

devices."[7] Since appellant is not dependent on an assistive device and his limp appears to be caused only by subjective factors such as pain or sudden giving away, Dr. Paul erred in his consideration of an impairment rating based on gait derangement.[8]

The Office medical adviser, Dr. Krohn, properly calculated appellant's two percent impairment based on a diagnosis of partial medial meniscectomy with proper reference to the A.M.A., *Guides*. Board precedent is well settled that when an attending physician's report gives an estimate of impairment, but the attending physician fails to correlate his findings with the A.M.A, *Guides*, or otherwise provide a detailed and reasoned opinion addressing how he reached his impairment rating with reference to the A.M.A., *Guides*, the Office is correct to follow the advise of its Office medical adviser where he or she has properly utilized the A.M.A., *Guides*.[9] Thus, the Board concludes that appellant has failed to provide probative, supportable medical evidence that he has greater than the two percent impairment already awarded.

The decision of the Office of Workers' Compensation Programs dated September 5, 1997 is hereby affirmed.

Dated, Washington, D.C.
October 15, 1999

George E. Rivers
Member

David S. Gerson
Member

A. Peter Kanjorski
Alternate Member

[7] *See* section 3.2, Gait Derangement, page 3/75 of the A.M.A., *Guides*.

[8] *Id.*

[9] *See Ronald J. Pavlik*, 33 ECAB 1596 (1982); *Robert R. Snow*, 33 ECAB 656 (1982); *Quincy E. Malone*, 31 ECAB 846 (1980).